

MIDWIFERY AND GYNÆCOLOGY.

Antiseptic Midwifery.

Dr. G. EUSTACHE, of Lille, in a general review of obstetrics, asks concerning the means for preventing puerperal sepsis:—

1. *How shall puerperal infection by the accoucheur be prevented?* The physician is only too often the vehicle of infection. He is called to see a case of puerperal fever, to make an autopsy, etc., in the exercise of his profession. Under these circumstances should he, in order to keep from infecting other patients, abstain from practice for a certain length of time? And for how long a time? or may he not render himself non-infecting by the proper use of antiseptics?

These questions have been fully discussed in Germany during the past six months. Professor Swiecickie, of Erlangen, in a paper read before the Obstetrical Society of Berlin, expresses the opinion that, after attending a case of puerperal fever, the physician should not attend another labour case within a week at the least. However prudent this suggestion is, it would be extremely difficult to comply with it. Löhlein, on the contrary, states that it is not necessary to refrain from practice at all, if proper antiseptic precautions be taken, and Fritsch and Wiener, of Breslau, have taken the same ground. At the same time Eustache believes that the handling of a puerperal woman by one who is engaged in dissecting is very unwise, and should not be countenanced.

2. *What is the best antiseptic for the accoucheur?* The antizymotic and disinfectant properties of corrosive sublimate have been known for some time, but only within a comparatively short time has it come into use as an antiseptic. It is now believed, in Germany, to be the antiseptic agent, *par excellence*, for obstetrical practice. Various solutions have been recommended. Some use a solution of 1 to 1000, but the greater number seem inclined to use weaker solutions, say, 1 to 1500, 2000, or 2500.—*Archives de Toxicologie*, Feb. 1884.

Vaginal Cysts.

Dr. MAX GRAEFE, of Berlin, contributes to a recent number of the *Zeitschr. f. Gezurts. u. Gynäk.* a short but interesting paper on vaginal cysts. He believes that these are less uncommon than is generally supposed, because they generally cause no suffering, and therefore are probably often unnoticed. He gives an account of ten cases under his own observation (occurring in Professor Schræder's clinic), in each of which a careful microscopical examination of the cyst wall was made. Adding to these cases published by Winckel, Klebs, and other writers, our author arrives at the following conclusions: Out of 61 cases, in 29 the cyst was on the anterior vaginal wall, in 21 on the posterior, and in 11 laterally situated. He points out that this statement must be taken with the qualification that in many cases the cyst is not seated exclusively upon either vaginal wall. The colour, consistence, and morphological elements of the cyst contents differ widely even in cysts apparently similar in structure. The thickness of the cyst wall varies from a millimetre to a centimetre. It is composed of connective tissue, with, in thick-walled cysts, smooth muscular fibres, that is, the structure of the vagina. Outside it is covered with pavement epithelium, like that of the vagina. Internally most cysts are lined with cylindrical epithelium, but now and again we find a single or several layers of pavement epithelium. There may be in the same cyst cylindrical epithelium at one part and pavement at another, as shown by Lebedeff, and in three of Dr. Graefe's cases. After describing their anatomy, our author discusses the different opinions that have

been entertained as to their origin. Klebs looks upon them as dilated lymphatic vessels, for the reason that he has found them lined with lymphatic endothelium. Dr. Graefe has only been able to find records of three cases in which the interior had such a covering; and even in them he does not think that the inference follows, that the cyst must have arisen by dilatation of a lymphatic vessel, because Lebedeff¹ has shown that cylindrical may, in these cysts, become changed into pavement epithelium. For the rare cases in which the cyst is without any epithelial lining, Dr. Graefe accepts Winckle's suggestion, that they may be merely spaces in the submucous connective tissue resulting from œdema, injury, or hemorrhagic effusions. Cysts provided with an epithelial lining he regards as retention cysts, due to occlusion of the orifices of vaginal glands. He accepts the evidence brought forward by Von Preuschen as to the occasional existence of glands in the vagina. He points out that there is a stage in the development of the vagina in which it is lined by cylindrical epithelium, and refers to a case reported by Dr. C. Ruge, in which that observer found a small cyst on the vaginal portion of a fœtus of four months' development. Dr. Graefe therefore puts it, that the membrane lining a vaginal cyst, in producing cylinder epithelium, is "true to its embryonic tradition." There are, however, also cases in which the interior of the cyst presents a structure identical with that of the vagina itself. Of such our author thinks Veit's conjecture a probable explanation, viz., that they are formed out of the remains of the duct of the Wolffian body. Freund has suggested that some cysts may be rudiments of the ducts of Müller; and Dr. Graefe thinks this explanation applicable to one of his cases, in which there were six cysts, arranged in a row one behind the other. Another of his cases, in which there were three cysts, but not serially arranged, he thinks may be accounted for by the combined hypotheses of Veit and Freund.

In the same number of the *Zeitschrift* we find a short paper by Dr. J. Veit, published as a kind of appendix to that of Dr. Graefe, in which is described a case of a vaginal cyst of unusual size, as large as a child's head, projecting from the vulvular orifice in such a manner as at first sight to resemble prolapsus, and above reaching to the broad ligament. Dr. Veit thinks it probably originated in the remains of the Wolffian duct.—*Med. Times and Gaz.*, January 5, 1884.

Etiology of Fungous Endometritis.

A recent number of the *Archiv für Gynäkologie* contains a long, but somewhat theoretical paper by Dr. BRENNÉCKE on the etiology of fungous endometritis, more especially of the form described by Olshausen under the name of "chronic hyperplastic endometritis." The weakness of this carefully written paper is in the small number of cases upon which it is based. Of the disease described by Olshausen, the author believes there are two forms—a glandular, in which overgrowth of gland-tissue is the conspicuous change; and an interstitial, marked by hyperplasia of the connective tissue. Between these extreme forms, other mixed or intermediate cases occur, in which both changes are present. The interstitial form occurs in the younger, the glandular form in the older patients. Dr. Brennecke describes six cases observed by himself, and refers to some other published cases, and upon this material he builds his theory. He finds that in them all the hemorrhage and other symptoms characteristic of the disease were preceded by periods either of complete amenorrhœa, or of irregular, infrequent, and scanty menstruation. Therefore, he says, the disease depends primarily upon a functional disturbance in the ovaries, which, as a reflex effect,

¹ Medical Times and Gazette, 1883, vol. 1. p. 13.

causes chronic hyperæmia of the uterine mucous membrane, and thus leads to hypertrophy of that structure. This reflex effect is produced through the nervous mechanism which governs ordinary menstruation, and it therefore affects the body only, not the cervix, of the uterus. Being a disease due to reflex action, it cannot be cured while the cause of the reflex effect remains in operation. Hence, says Dr. Brennecke, the frequency of relapse which is observed in this disease. Our author also adduces the occasional association of abscess of the ovary with this morbid condition in support of his view. For the treatment of this form he looks on the curette, used to remove the hypertrophied membrane, as the grand agent. This should be combined with tonic medication to alter the morbid action which leads to its formation. Cauterization he thinks useless, its adoption being based on an erroneous view as to the pathology of the disease, viz., that it is merely a local change in the uterine mucous membrane. He does not think that this malady ever passes into cancer. The form of disease in which there are localized fungous outgrowths in the uterine cavity, Dr. Brennecke in his experience has always found dependent on some other disease of the uterus; either chronic catarrh (simple or gonorrhæal), retroflexion, stenosis of the os internum or externum, interstitial or submucous fibroids. This form he therefore calls the local uterine form, in contradistinction to the cases of chronic hyperplastic endometritis, which, in accordance with his theory, he calls the ovarian form. He points out these distinctions: 1. In the uterine form there is hemorrhage from the beginning; in the ovarian, menstruation is at first deficient or absent. 2. In the uterine form there is scarcely any tendency to relapse; in the ovarian, a strong tendency. 3. The fragments removed by the curette are smaller in the uterine form than in the ovarian. 4. In the ovarian form these pieces show the structure simply of hypertrophied mucous membrane; this being seldom the case in the uterine form, in which the products of catarrh and ulceration are commonly found. Lastly, Dr. Brennecke describes fungous endometritis following abortion, which he denominates the decidual form. These cases yield the most satisfactory results to treatment, being commonly completely cured by once using the curette. Dr. Brennecke adds to his paper an interesting novelty in the shape of a plate, in which the course of some cases of fungous endometritis is shown in a graphic form.—*Med. Times and Gaz.*, Dec. 8, 1882.

New Method of Partial Extirpation of the Cancerous Uterus.

Dr. ELY VAN DE WARKER, in a paper on this subject in the *American Journal of Obstetrics*, March, 1884, says that at this period the treatment of malignant disease of the uterus is narrowed down to three methods: total extirpation of the uterus through the vagina, vaginal amputation with supra-vaginal excision, and his own method of potent chemical cautery. The first is a method attended with such a ratio of direct fatality and with such mechanical difficulties in the way of its performance that ovariectomy is safe and simple in comparison. The second is simply a survival of the antique. The third, his method, of chemical cautery is as follows:—

The first step consists in amputation of the cervix uteri up to the vaginal junction. The cervix is seized in some portion of its periphery where the tissue is sufficiently firm to hold, with a double volsellum, and the part cut away with a scissors curved on the flat. If the part is very indurated and thick, a knife with a suitable handle is the better instrument. From this point the tissue of the cervix is excised, usually as high as the os internum, in the form of an irregular

triangle, with the base at the vaginal junction. We may do this with either the knife, scissors, or curette, whichever is most convenient. In case the tissues in the cavity of the cervix are very friable, a curette will answer every purpose. With this instrument we may follow the spongy tissue down into depressions of the firmer parts, and then using the scissors, smoothe off the irregularities to a general level. In case of considerable depth of indurated tissue in the cervical cavity, a knife that may be placed at different angles is necessary. Hemorrhage has never given me any serious trouble at this stage. In several cases there has been free loss of blood, which ceased as soon as the cavity was thoroughly cleaned out.

He believes that, in the majority of cases, packing the excavation, after the manner of Sims, with iron cotton as a precaution against hemorrhage, is not necessary, and that we might proceed at once to the second step of the operation, as the zinc solution is in itself a powerful astringent.

When cotton is used it must be promptly removed on the first suspicion of blood-poisoning. Dr. Van de Warker packs the uterus with masses of absorbent cotton about the size of a chestnut, wrung nearly dry from the iron solution, made of one part of subsulphate of iron to three of water. If the cotton is used in small, separate masses, the cavity may be packed without the use of any force, as larger or smaller pieces may be chinked in where they are needed. In removing the iron dressing, these small pieces may be taken away separately with much less force than the large. Very little packing is required in the vagina, as the iron cotton keeps its place very firmly, while filling the vagina adds very much to the discomfort of the patient and prevents the free action of the bladder. The use of carbolized or aseptic cotton in the vagina in no way prevents decomposition. We can, in a measure, avoid blood-poisoning, which is so liable to follow the decomposition of blood-clots saturated with iron, by carefully removing all clots from the uterine excavation, and if we find the blood oozing from between the masses of cotton, remove all the dressing and repack, rather than insure against hemorrhage by imprisoning the exuded blood, by packing the vagina, as the blood is sure to decompose and prove the source of a vile odour, if not of absolute danger.

The dressing ought to be removed by the second day. This is done more readily with a tenaculum with a short, right-angled hook. Here the chief advantage arises of using small masses of the iron cotton, as each one may be caught up on the tenaculum, and removed separately without any force. The patient should be placed upon the table in a good light, as the vagina will be found discoloured by the iron, and very much contracted. When the vagina and uterine excavation are properly cleaned out, the patient is ready for the real operation, compared to which all that has gone before is subsidiary and of minor importance.

Dr. Van de Warker makes use of two strengths of the zinc chloride solution, one of 3v to the ounce of water, and one of equal parts of the chloride and of water, by weight. The zinc solutions, about an ounce of each, in salt mouth bottles, are marked so that there may be no doubt which is the stronger. A pomade of bicarbonate of soda in vaseline, about one to three, and a thirty-per-cent. solution of the same salt in a goblet. An assistant accustomed to hold a Sims speculum is very necessary. After the dressing of iron cotton is removed, he cleans and dries the vagina and excavation with absorbent cotton, and then carefully protects the labia and vagina with the pomade of bicarbonate. The comfort of the patient for two weeks or so depends upon protecting the labia, and, especially, the urinary meatus, from the action of the caustic. Since using

the vaseline pomade, he has had no trouble. How are we to determine whether we will use the weak or one-hundred-per-cent. solution? This point is determined at the completion of the preliminary operation. By introducing a blunt sound to the fundus of the bladder, and with the finger passed into the uterine excavation, he endeavours to feel the sound through the intervening part, and thus estimate the amount of tissue left for the caustic to act upon. The posterior relations of the cavity are judged of in like manner, by passing the sound into the uterine excavation, and with a finger in the rectum, if the interlying part is very thin, the sound may be felt. It is better to do this before the excavation is hardened and contracted by the iron. If, then, we have approached quite near the surface of the uterus, so that a slough in excess of a quarter of an inch in thickness is liable to result in perforation, it is prudent to use the weak solution after the upper and thicker-walled parts of the excavation have been packed with the strong solution. If the vaginal wall was involved and worked down with the curette, it is possibly better to use the weaker mixture for fear of perforating into the bladder or rectum, although he has applied the one-hundred-per-cent. solution upon the vagina without accident. Usually, we need not hesitate to expose the surface operated upon to the full strength of the caustic. After the packing is completed, the surface of the zinc cotton and about an inch of the upper vagina is filled with absorbent cotton saturated with the bicarbonate of soda solution, by which any of the chloride of zinc that may filter out is decomposed.

In some instances, the pain is not severe. One or two full doses of morphia, hypodermically, are sufficient to bridge over the period of pain, which usually does not exceed ten hours. In about two or three days, we may remove the cotton from the vagina, and, if we can do so without force, from the uterine excavation. If the zinc dressing is thoroughly cemented down, it is better to wait a day or two longer. When it is removed, a white, firm, cement-like surface, which is the slough firmly adherent to the excavation, is brought into view. The slough will separate in from five to ten days. No force at any time should be used to detach the slough, but it must be allowed to exfoliate spontaneously. If the one-hundred-per-cent. chloride solution has been used, it is thrown off in a single piece, an exact cast of the cavity. There is no danger of blood-poisoning during this stage, as the chloride is a perfect disinfectant. While the slough is separating, we may aid the process by a free douche of carbolic acid solution, which may be continued during the granulation process.

It is during the sloughing stage that we may be annoyed by hemorrhage. He guards against it by confining the bowels for four or five days, as then there will be no cause for expulsive effort upon the bed-pan. The patient is cautioned against sitting up in bed or making any considerable effort to help herself. It is better to empty the bladder through the catheter at this time, as patients get to be very careless if allowed to help themselves. On several occasions, he has seen hemorrhage follow directly after using the douche. This, he thinks, was owing to the force of the current into the excavation. None but the gentlest stream must be used, and, if hemorrhage should follow, stop the injection for a day or two. In cases in which the destruction by the caustic of the muscular tissue of the uterus has been extensive, there has been less hemorrhage than in cases in which a considerable part of the substance of the organ was intact. In one case, in which he had reason to believe, from the shape and quantity of the slough and the depth and breadth of the excavation, that the entire uterus had been shelled out of its peritoneal envelope, there was only a slight hemorrhage on the sixth day, caused by the patient getting up and sitting upon the commode.

The hemorrhage ceased spontaneously: He has never been obliged to pack the vagina to arrest hemorrhage. An injection of a weak subsulphate of iron solution has always promptly arrested it. It is not a good form of astringent to use, however, as the bed is liable to be damaged. Vinegar or a solution of alum would be just as efficient, and without this disadvantage. The use of vinegar would not constrict the vagina, and thus allow one to pack in case this became necessary—a very difficult thing to do after an iron injection.

Cicatrization is completed in from two to four weeks, leaving a greatly contracted cavity lined by a pale, soft, velvety membrane free from odour or discharge. The cavity continues to contract for some time after the granulation process is completed. Contractions such as this would follow no agent other than a caustic. It is an endowment of cicatricial tissue from this cause to undergo this progressive shrinkage, as the deformities from severe burns prove.

Three cases are reported which illustrate the various methods of the procedure.

The Complications of Cancer of the Uterus.

In a recent paper on this subject MM. FÉRÉ and CARON give the results of 51 autopsies made in 1881, 1882, and 1883 at the Salpêtrière. Cancer of the uterus is certainly a frequent disease, and the study of its complications has not been neglected by writers on the subject.

Of 51 cases of cancer of the uterus there were: 1 case of primary cancer of the uterine body with complete integrity of the cervix; 3 cases which had wholly invaded the body and cervix; 47 cases in which the cancer, having destroyed the whole or a part of the cervix, had invaded more or less of the isthmus and the lower part of the uterine body.

The complications observed may be grouped in the following manner:—

I. *Lesions of Contiguity.*—a. *Invasion of the vagina.* In 35 cases the vagina was invaded to a greater or less extent, and in some cases as far as the vulva. b. *Invasion of the bladder.* In 27 cases the uterus was adherent to the posterior wall of the bladder; in 18 the bladder communicated with the vagina, and the trigonum was completely destroyed in six cases. The bladder in every case was more or less thickened, indurated, and mammeloned; there were also vascular ramifications around the urethra; in 1 case there was in the vicinity of the urethra true thrombosis of two veins, each containing a yellow clot. In one case the bladder was studded with small transparent miliary cysts which gave a violaceous colouring to the mucous membrane. c. *Invasion of the rectum.* In a certain number of cases there were adhesions with the rectum; in 7 there were communications with that organ, and in one of these cases there was a second communication with the small intestine. In another case there was an induration of the rectum to the extent of four inches, and, in the centre, a spot of softening whence two fistulæ extended into the perineum. Rupture of these adhesions to the rectum caused death in 3 cases by setting up a purulent peritonitis. d. *Peritoneal lesions.* General peritonitis has been found in 9 cases.

II. *Propagation to Ganglia.*—The ganglia of the large ligaments were seriously involved in 9 cases; in another the sacro-lumbar ganglia were involved; in still another cases there was a chain of cancerous nodules along the psoas muscle.

III. *Generalization.* Five cases.—In one case the intestinal walls were studded with miliary cancerous nodules. In the second there were also three cancerous foci in the left lung. There were 10 or 12 nodules, as large as a hazel-nut, in the liver, which was hypertrophied and cirrhotic. There was a

nodule in the heart, as large as a chestnut, indurated, developed in the wall of the right ventricle, and projecting into the interior of the ventricle by several small vegetations ulcerated at the summit. The uterus was completely invaded, the bladder was involved, and the whole pelvis was filled by a hard, irregular mass of fibrous aspect. There was also a cancerous pelvic peritonitis. In the third case the cervix and the isthmus were destroyed, and the recto-peritoneal cul-de-sac was filled with cancerous nodules. The caecum was the seat of a cancerous mass which had destroyed the ilio-caecal vulva. The whole abdominal cavity was filled with small cancerous nodules situated in the epiploon, the mesentery, and the intestinal loops. In the fourth case there was cancer of the left parietal bone, small cancerous spots in the pleura, a cancerous mass of the uterus which had destroyed the cervix, and cancerous nodules on the mucous membrane of the base of the bladder, and a few nodules on the upper surface of the diaphragm. In one case there was an encephaloid tumour of the right ovary as large as the head of a fœtus.

IV. *Lesions of the Urinary Passes of Mechanical Origin.*—There was, in 21 cases, dilatation of both ureters; in 19 cases, dilatation of one alone, nine times on the right, and ten times on the left, followed by dilatation of the calices and pelves, double in 21 cases, and on one side only in 16, nine on the right, and ten on the left.

These dilatations, caused by more or less slow occlusion of the ureters, caused hydronephrosis in the majority of the cases; in other cases there was pyelitis, with 7 cases also of suppurative pyelitis. In 2 cases there were calculi in the calices, the pelves, and ureters. There were also kidney lesions; in the greater number of the cases the cortex was sclerotic. In 7 cases there was double interstitial nephritis, and 17 cases in which the lesion existed only on one side; in one case the kidneys were the seat of numerous small cysts. In 7 cases there were miliary abscesses of the kidneys.

V. *Cardio-Vascular Lesions.*—There were 2 cases of thrombosis of the iliac veins; in 3 cases there were thrombosis of the Sylvian artery and cerebral softening. In 8 cases there were traces of recent intra-cardiac lesions, and condylomatous vegetations with or without vascularization of the valves. The cardiac lesions only existed in cases in which there were renal lesions.—*Progrès Méd.*, Dec. 29, 1883.

Three Cases of Pyosalpinx.

At the meeting of the Obstetrical Society of London, on Nov. 7th, Mr. LAWSON TAIT related three cases of acute peritonitis, due to pyosalpinx, cured by abdominal section, removal of the diseased appendages, cleansing and draining of the peritoneum. The first case was one of chronic pyosalpinx made acute by a stem pessary. The tube burst, and acute peritonitis followed. Abdominal section was promptly performed, and the patient saved. Mr. Tait quoted the remarks of the gentleman who sent the case to him, as to the effect of the mechanical treatment in causing the disease, the difficulty in discriminating the cases suitable for treatment by stem pessaries, and the dangers of these instruments. The second case had already been published in the *British Medical Journal* of February 17, 1882, and was brought forward here for the purpose of recording the subsequent history, which was that all the symptoms had vanished, and the patient was now perfectly well. The third case was one of purulent peritonitis arising from rupture of a suppurating Fallopian tube. The pyosalpinx was due to gonorrhœal infection. The left tube only was removed. The patient recovered completely. Mr. Tait had now operated on sixty-five cases of occlu-

sion and distension of the Fallopian tube without a death. In only one had there been failure to completely relieve the patient's sufferings. Six cases had been lost sight of, and two had died since the operation, from causes independent of it. The author remarked that cases such as these could not be relieved by anything short of removal of the diseased organs; and that they existed in large numbers, forming a large portion of the cases which wander about from one practitioner to another, seeking relief. He also complained of some unjust and ungenerous criticisms which were frequently repeated to him, and he asked those who expressed such views to come and see his work.

Dr. WYNN WILLIAMS protested against the use of a stem pessary in such a case as the one related. If harm followed the use of a stem in such a case, the blame should be laid on the practitioner, not on the instrument. He presumed the pyosalpinx was not attributed to the stem, as it must have been there previous to the insertion of the instrument.

Mr. DORAN believed that suppuration of the Fallopian tube was sometimes caused by the introduction of a dirty sound into the uterine cavity, conveying septic matter therein, and setting up a low form of inflammation.

Dr. W. A. DUNCAN asked whether, in many of his cases, the tubes were fixed by adhesions, and, if so, whether the operation was made much more difficult? He had recently seen two cases of pyosalpinx; in one, the left tube ruptured into the vagina; in the other, a very characteristic left pyosalpinx entirely disappeared.

Dr. GERVIS thought that Mr. Tait took somewhat too gloomy a view of the prognosis in cases of tubal distension. Some cases, possibly of hydrosalpinx, certainly got better without operation. He thought that whatever induced endometritis might lead to tubal inflammation. He asked for further information as to the diagnosis of these cases. He thought that this operation, though the latest, was not the least important of recent advances in abdominal surgery.

Mr. KNOWSLEY THORNTON asked for the respective numbers of the cases of hydrosalpinx and pyosalpinx. He could not admit that hydrosalpinx was a grave condition; he had met with it often in performing ovariectomy, and believed that its bursting caused little or no disturbance, and was a common mode of its natural cure. Pyosalpinx was more serious, but he believed it was often cured by discharging into the uterus. The distinction between these two conditions was, therefore, of much importance, and he asked for information as to the diagnosis between them. He had twice operated for pyosalpinx, and in neither case were there more than slight adhesions.

Dr. MATTHEWS OWENS had seen some fifteen of these operations, and could vouch for the great good done by them. He believed that many cases of so-called hysteria would now prove to be due to disease of the Fallopian tube. He mentioned a case in illustration. Such cases were not recorded in post-mortem records, because they were put down as peritonitis. The difficulty of diagnosis of these cases was a drawback. But the risk of an exploratory incision was *nil*, and the result, if pyosalpinx were found, brilliant.

Mr. LAWSON TAIT said that the words condemning the stem pessary were not his own. He had known gonorrhœa given by a dirty speculum, and thought it might be given by a dirty sound. If he were called to a case of puerperal peritonitis sufficiently early to promise a good result, he would open the abdomen, wash out and drain the cavity; but as yet he had not had a chance of doing this. He had no doubt that many cases of hydrosalpinx and some of pyosalpinx were cured by natural processes. In diagnosis, he depended largely on the history, which started from an inflammatory attack. There was more or less con-

stant pain, aggravated by movement and by intercourse, and menorrhagia; and there were physical signs of pelvic changes. Errors in diagnosis occurred in his practice about once in ten times, and were always instructive. He mentioned cases in which he had taken for pyosalpinx a small dermoid cyst. In these, the initial point in the history was the only thing wanting. Cases of pyosalpinx were not seen in hospital post-mortem rooms because they commonly died from peritonitis too quickly to come into hospital. They were, however, exceptionally seen in hospitals. Hydrosalpinx and pyosalpinx occurred in his practice, he thought, in the proportion of about three to two. Hydrosalpinx was not dangerous to life, but often caused intense suffering, and therefore he did not hesitate to remove it. He did not think its rupture ever likely to prove fatal. The differential diagnosis between the two could not be made. He used a glass drainage-tube and washed out the abdomen with plain water. He expressed his gratification at the reception of his paper.—*Med. Times and Gaz.*, Dec. 1, 1883.

MEDICAL JURISPRUDENCE AND TOXICOLOGY.

Suicide by Pistol-shot without External Wound.

Dr. FRANK OGSTON reports, in the *Edinburgh Medical Journal*, Feb. 1884, a most remarkable case in which a man committed suicide by shooting himself in the mouth, and in which no external wound was made.

The lips, externally as well as internally, were quite uninjured. The whole of the interior of the mouth was blackened. A blackened groove, a quarter of an inch in breadth and depth, ran along nearly the whole dorsum of the tongue. The velum palati perforated by a round hole, nearly a quarter of an inch in diameter, exactly in the central line and near its lower margin. The basilar process of the occipital bone presented a similar perforation just in front of the foramen magnum. The bullet had then traversed the medulla oblongata, and striking the inner side of the occipital bone at its thickest part, the internal occipital protuberance, had glanced off and run through the brain from the left side of the base of the cerebellum, traversing the right lateral ventricle, and issuing from the cerebrum between the third and fourth right frontal convolutions; then, apparently its velocity almost spent, it had spun backwards over the surface of the brain, and was found in a mass of bruised and broken-down brain matter underneath the dura mater, over the fissure of Sylvius on the left side, near the superior longitudinal sinus.

Beyond the perforations above described, the bones of the skull showed no mark of the bullet, and were quite uninjured. The bullet was battered almost out of shape, but its base retained still enough of its original form to admit of its identification, as it nearly fitted into the copper capsule out of which it had been fired, which was found in the revolver.